MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04106

Reg. Dist. No. 231

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Prince Georges
City or town Cheverly Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred:
Prince George gen. Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince George
City or town Bowie
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Anderson Mrs. Belle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Anderson, Mr. Basil
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) March 17, 1866

8. AGE: Years 79 | Months 1 | Days | If less than one day ... hrs. ... min.

9. Birthplace D.C.
(Town, county, and state)

10. Usual occupation H. W.

11. Industry or business

FATHER
12. Name Brownell, Mr. Chas
13. Birthplace D.C.

MOTHER
14. Maiden name Havenhill Emma
15. Birthplace D.C.

16. Informant Hackett, Mrs. M.
Address Bowie Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof April 26/45 (month) (day) (year)

Cemetery or crematory Holy Trinity
Location Collington Md

18. Funeral director The H. C. Hyde Co.
Address Laurel Md.

19. Apr 27 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1945, at 8:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1944, to April 22 1945 and that I last saw h-- alive on April 21 1945

Immediate cause of death Cerebral thrombosis — DURATION 10 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert J McCeney M.D.
M. D. or other
Address Laurel Md Date signed 4/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 464

04105

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH: Prince George

County

City or town Berwyn Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pr Geo.

City or town Berwyn Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8514 Cunningham Dr.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bessie Bee Ball

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband ~~or wife~~ Chas. E. Bace

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Mch 19th 1882

8. AGE: Years	Months	Days	If less than one day
63	0	14	....hrs. ....min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Wm A. Turner

FATHER 13. Birthplace Baltimore

MOTHER 14. Maiden name Anna B. Gardiner

MOTHER 15. Birthplace Baltimore

16. Informant Chas E. Bace

Address Berwyn Heights

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 6 1945 (month) (day) (year)

Cemetery or crematory Ft. Lincoln

Location Cottage City Md

18. Funeral director F. Gaspich Sons

Address Hyattsville Md

19. April 4th 1945 (Date rec'd by registrar) Joshua D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3rd 1945 at 6 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1st 1944 to April 2 1945 and that I last saw h.. alive on April 2 at 1945

Immediate cause of death	DURATION
Carcinoma of Liver	1 yr +
Due to	
Due to	
Other conditions Arteriosclerosis	2 yrs +

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. P. Etienne M. D. or other

Address Berwyn Date signed 4/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04167

Reg. Diet. No. 243.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 5 days

Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 2 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2382 Champlain St. N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: ESTELLA BARNETT

3.(b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married (separated)

6.(b) Name of husband or wife: Pierce Barnett

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): April 30, 1917

8. AGE: Years	Months	Days	If less than one day
27	11	29	..... hrs. ..... min.

9. Birthplace: Washington, Georgia (Town, county, and state)

10. Usual occupation: Cleaning Maid

11. Industry or business:

FATHER — 12. Name: John T. Henderson

13. Birthplace: Washington, Georgia

MOTHER — 14. Maiden name: Daisy Norman

15. Birthplace: Washington, Georgia

16. Informant: Decedent

Address:

17. (Burial, cremation, or removal. Which?) Removal — Date thereof: 4 - 28 - 45 (month) (day) (year)

Cemetery or crematory: to Wash.

Location:

18. Funeral director: R. H. Horton

Address: 1322 V St. NW

19. Apr. 28 1945 (Date rec'd by registrar) Rowland & Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 28 1945, at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 23 1945, to APRIL 28 1945

and that I last saw h...R alive on APRIL 28 1945

Immediate cause of death: PULMONARY TUBERCULOSIS — DURATION: 3 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pincura M.D. (M. D. or other)

Address: Glenn Dale Md. Date signed: 4-28-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-e

CERTIFICATE OF DEATH

04108

Reg. Dist. No. 240

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Prince Georges

City or town Brandywine

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Brandywine

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Early Bowie

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1877

8. AGE: Years 68 | Months 0 | Days 23 | If less than one day ... hrs. ... min.

9. Birthplace Brandywine Md (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Robert Bowie

13. Birthplace Maryland

MOTHER 14. Maiden name Margaret Alice Early

15. Birthplace Maryland

16. Informant Alan Bowie

Address Brandywine, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 7, 1945 (month) (day) (year)

Cemetery or crematory Trinity

Location Upper Marlboro Md

18. Funeral director Fletcher Bros

Address Upper Marlboro Md

19. April 5 1945 (Date rec'd by registrar) F. H. Billingsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945, at 8:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 35, to April 5 1945

and that I last saw him alive on April 3 1945

Immediate cause of death	DURATION
Congestive Heart Failure	
Due to Senescis Nervosa	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard D. Boyd M. D. or other

Address Forestville Md Date signed 4-5-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(41) 243 Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Prince Georg's
City or town: Mitchelwill R F D #2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Mitchelwill R F D #2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME Mary Stella Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Andrew Brown
6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): September 20 1912

8. AGE: Years	Months	Days	If less than one day
32	6	19	hrs. min.

9. Birthplace: Lumber Bridge, N.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Farm
FATHER 12. Name: John D. Ray
13. Birthplace: N.C.
MOTHER 14. Maiden name: Addie Albreaths
15. Birthplace: N.C.
16. Informant: Andrew Brown
Address: Mitchelwill, Md
17. (Burial, cremation, or removal, Which?) transportation Date thereof: April 11. 1945 (month) (day) (year)
Cemetery or crematory: Parkton North Carolina
Location: North Carolina
16. Funeral director: Foreacre Funeral Home
Address: Wood Row Md
19. Apr 10 1945 (Date rec'd by registrar) Louise H. Peach Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 1945, at 10:05 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 10 1945, to April 8 1945
and that I last saw her alive on April 7 1945
Immediate cause of death: Bronchial Pneumonia — DURATION: 4 days
Due to: Secondary Anemia — 3 months
Due to: Malnutrition — 2 months
Other conditions: Congestive Heart Failure — 6 months
(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James C. Sasscer M. D. or other
Address: Upper Marlboro, Md Date signed: 4-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04110

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 9 mos., 5 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 9 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1435 Coccoran St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: BROWNE, ROBERT LEONARD

3.(b) Social Security Number: 578-20-1972

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 19, 1923

8. AGE: Years	Months	Days	If less than one day
21	5	8	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Messenger

11. Industry or business

FATHER
12. Name: Wilson Brown
13. Birthplace: Virginia

MOTHER
14. Maiden name: Annie Brown
15. Birthplace: Virginia

16. Informant: Decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-28-45 (month) (day) (year)
Cemetery or crematory: to Wash D.C.
Location

18. Funeral director: Malcom F. Sibley Inc.
Address: 424 R St N.W. Wash D.C.

19. Apr. 27 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27 1945 at 7:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/22 1943 to 4/27 1945
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Tuberculosis Pulmonary	22 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Pinucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed 4/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (945)

CERTIFICATE OF DEATH

04111 Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince George
City or town Cottage City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Cottage City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3704 - 40th. Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Anna Caherty.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband ~~or wife~~ Hugh P. Caherty
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 14, 1891

8. AGE: Years	Months	Days	If less than one day
53	9		hrs. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Francis Oscar Hetrick
13. Birthplace Philadelphia, Pa

MOTHER
14. Maiden name Anna Barbara Lutter
15. Birthplace Philadelphia, Pa

16. Informant Mrs. Margaret Butler
Address 3704 - 40th. Ave. Cottage City

17. burial, (Burial, cremation, or removal. Which?) Date thereof 4-17-1945 (month) (day) (year)
Cemetery or crematory Mt. Olivet Cemetery
Locafion Washington, D. C.

18. Funeral director William J. Malley
Address 3200 - R.I. Ave. Mt. Rainier, Md.

19. April 16 1945 Jas Devery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 13 1945 at 5 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 - 11 1945, to 4 - 13 1945 and that I last saw h~~er~~ alive on 4 - 13 1945

Immediate cause of death	DURATION
Coronary Occlusion	4-11-45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, soicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George J. Hagerty M. D. or other
Address 3217 38th Ave. Date signed 4-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

04112

Reg. Diat. No. 245

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Prince George

City or town Queen Chapel Manor (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred: 2903 - Kennedy St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Queen Chapel Manor (If outside city or town limits, write RURAL and give nearest town)

Street No. 2903 - Kennedy Street (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Amelia Caspers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Francis X Caspers

6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) February 3, 1881

8. AGE:

Years	Months	Days	If less than one day
64	2	9	hrs. min.

9. Birthplace Washington DC (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Adam Hatzfeld

FATHER 13. Birthplace Germany

MOTHER 14. Maiden name Mary Amelia Bleifuss

MOTHER 15. Birthplace Germany

16. Informant Francis X Caspers

Address 2903 - Kennedy St, Queen Chapel Manor

17. Removal (Burial, cremation, or removal. Which?) Date thereof April 12 45 (month) (day) (year)

Cemetery or crematory

Location 641 - H St. N.E. Wash. D.C.

19. Funeral director Albert Aske

Address 641 - H st. N.E. Wash. D.C.

19. April 12 1945 (Date rec'd by registrar) Jas Leary Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1945, at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cardio vascular renal disease	
Due to Acute Congestive heart failure	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner

23. SIGNATURE James D Boyd M. D. or other

Address Forestville Md Date signed 4-12-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1176

CERTIFICATE OF DEATH

04113

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:
Prince Geo. General Hospital

How long in hospital or institution? Cheverly, Md. 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2013 Kearney St. S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Castell, John Marion

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Castell, Mrs. Emma
(Wife) 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 16, 1878

8. AGE:

Years	Months	Days	If less than one day
67	1	4	hrs. min.

9. Birthplace: District of Columbia
(Town, county, and state)

10. Usual occupation: Proof reader

11. Industry or business:

FATHER
12. Name: Castell, John H.
13. Birthplace: D.C.

MOTHER
14. Maiden name: Mrs. Kinsey, Elizabeth
15. Birthplace: Baltimore, Md.

16. Informant: Castell, Mrs. Emma
Address: 2013 Kearney St., S.E. Washington

17. Removal. (Burial, cremation, or removal. Which?) Date thereof: Apr. 20th 45 (month) (day) (year)

Cemetery or crematory:
Location: Washington, D.C.

18. Funeral director: A. D. Hines Co.
Address: 2901-14th St. Nash. D.C.

19. 4/20 19 45 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1945 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1945 to April 20 1945 and that I last saw h. alive on April 20 1945

Immediate cause of death	DURATION
Gastric Hemorrhage	7 hours.
Due to: Duodenal ulcer	8 weeks.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. H. Head M.D. M. D. or other

Address: 1833 Monroe St. N.W. D.C. Date signed: 4/20/45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Suitland Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Temporary
Hospital, institution, or street address where death occurred:
Naylor Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maine County:
City or town: Livermore Falls
(If outside city or town limits, write RURAL and give nearest town)
Street No. 45 Depot Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elliott James Clarke

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 4 1918

8. AGE: Years: 26 Months: Days: If less than one day: hrs. min.

9. Birthplace: Lewiston Me.
(Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U. S. Army

FATHER
12. Name: —
13. Birthplace: —

MOTHER
14. Maiden name: Nellie —
15. Birthplace: Frankfort Maine

16. Informant: U. S. Army Records
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 1 1945 (month) (day) (year)
Cemetery or crematory: Cemetery unknown
Location: Livermore Falls Maine
18. Funeral director: Chas. S. Gunkord Sons
Address: 301 E. Capitol St. Wash. DC
19. April 30 19 45 (Date rec'd by registrar) Sidney Brodman Capt. M.A.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1945 at 10 00 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to Crushed chest and abdomen	
Due to Being crushed under an automobile	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 4-30-45
Where did injury occur? Livermore Falls (City or town) Androscoggin (County) Maine (State)
Injured at home, farm, industry, public place (where?) Unpaved Army
Means of injury: Crushed under a truck At work? No

23. SIGNATURE: Deputy Medical Examiner M. D. or other
Address: Forestville Md. Date signed 4-30-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

CERTIFICATE OF DEATH

04114

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George.
City or town: Bladensburg Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Bladensburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4209 Edmonston Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Clarence W. Cochran Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age 15 years

7. Birth date of deceased (mo., day, yr.) 2-17-1930

8. AGE: Years	Months	Days	If less than one day
15	-	-	...hrs. ...min.

9. Birthplace: Wash. D.C. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Clarence W Cochran
13. Birthplace: Montgomery County.

MOTHER
14. Maiden name: Francis Waldenback.
15. Birthplace: Wash. D.C.

16. Informant: Father
Address: 4209 Edmonston Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-28-45 (month) (day) (year)
Cemetery or crematory: Mt Olivet.
Location: Wash. DC

18. Funeral director: Wm Reuben Dunphrey.
Address: Bethesda, Md.

19. 4/24 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 24 1945, at 1 48 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1940, to Apr 24 1945 and that I last saw h...alive on Apr 24 1945

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Epileptic seizures (Petit grand Mal)	5 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W H Norton M.D. (M. D. or other)
Address: 3827-34th St Mt Rainier Date signed: 4-24-45
md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04116 T

Reg. Dist. No. 242

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Prince Georges
City or town Glendale (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, institution, or street address where death occurred:
U. S. Govt Farm
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Glendale (If outside city or town limits, write RURAL and give nearest town)
Street No. U. S. Govt Farm (If rural, give LOCATION)
2.(a) If veteran, name war Civil war

3.(a) FULL NAME Stephen Parker Cowgill

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Sarah Austin Cowgill

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1845

8. AGE: Years	Months	Days	If less than one day
100	1	26	____ hrs. ____ min.

9. Birthplace Ohio (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name Wm Cowgill
FATHER 13. Birthplace unknown

MOTHER 14. Maiden name Sarah Chu[illegible]
MOTHER 15. Birthplace Ohio

16. Informant Mrs Mary Cowgill
Address Glendale Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 22, 1945 (month) (day) (year)
Cemetery or crematory St Georges
Location Glendale Md

18. Funeral director E Gusche sons
Address Hyattsville Md

19. Apr 26 1945 Mary Jack Barnette D.C. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1945 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ____ 19____, to ____ 19____ and that I last saw h[illegible] alive on ____ 19____

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardiovascular Renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

Deputy medical Examiner

23. SIGNATURE [illegible] M. D. or other
Address Forestville Md Date signed 4-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04117

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs., 8 mos., 17 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 yrs., 8 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 467 - O. Street N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3. (a) FULL NAME: JOHN DEAN

3. (b) Social Security Number: 578-18-6925

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
/ Male	Colored	Married

6.(b) Name of husband or wife: Vera Dean

6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): February 7, 1913

8. AGE: Years	Months	Days	If less than one day
32	2	15	..... hrs. ..... min.

8. Birthplace: Richmond, Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: John Dean
13. Birthplace: Virginia

MOTHER
14. Maiden name: Eliza Richardson
15. Birthplace: Virginia

16. Informant: Decedent
Address:

17. (Burial, cremation, or removal. Which?) Removal — Date thereof (month) (day) (year) Aprie 23 1945

Cemetery or crematory:

Location: to Wash D.C.

18. Funeral director: Ruth Dabney

Address: 442 - M - St. N.W.

19. (Date rec'd by registrar) Apr. 22, 1945 — Registrar: Rowland S. Phillips

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 22, 1945, at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 5, 1941, to April 22, 1945 and that I last saw h... alive on April 22, 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	5 yrs 10 mo.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 4/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

04118

Reg. Diat. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years.
Hospital, institution, or street address where death occurred:
Prince Georges General Hospital
How long in hospital or institution? 44 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges.
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6136 - Montrose Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Deckelman, Julia Clark

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widawed

6.(b) Name of husband or wife Joseph G. Deckelman.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1875

8. AGE:

Years	Months	Days	If less than one day
69	3	26	..... hrs. ..... min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name John Clark.
13. Birthplace Maryland

MOTHER
14. Maiden name Elizabeth Keller
15. Birthplace Maryland.

16. Informant Son - Mr. John P. Moreland
Address 6136 - Montrose Rd Cheverly, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof April 24-45 (month) (day) (year)
Cemetery or crematory Washington, D. C.
Location
18. Funeral director Albert J. Asle
Address 641 - A St. N. E.

19. 4/24 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945 at 10 05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1941 to Apr. 24 1945
and that I last saw her alive on Apr. 24. 1945

Immediate cause of death	DURATION
Carcinoma of Liver with metastases	4 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles C. Haggage M.D.
M. D., or other
Address Mt. Rainier, Md. Date signed April 24 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04119

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George Co
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 days
Hospital, institution, or street address where death occurred: Dr. Georges Gen. Hospital
How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Geo
City or town: 5743 - 1st St NE
(If outside city or town limits, write RURAL and give nearest town)
Street No. Wash. D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Benjamin Dellinger

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Doris Dellinger
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 5 1891

8. AGE: Years	Months	Days	If less than one day
53	5		hrs. min.

9. Birthplace: W. Va. (Town, county, and state)
10. Usual occupation: Mechanic
11. Industry or business

FATHER
12. Name: Benjamin Dellinger
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Minerva Miller
15. Birthplace: W. Va.

16. Informant: (Wife) Doris Dellinger
Address: 5743 - 1st St. NE Pr. Geo. Co.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4 (month) 24 (day) 45 (year)
Cemetery or crematory: Christ Church
Location: Clinton, Md

18. Funeral director: Butcher Bros
Address: Upper Marlboro Md

19. 4/24/45 (Date rec'd by registrar) Amanda Dancy, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24 1945, at 6 15/60 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27, 1945, to April 24, 1945; and that I last saw h alive on April 23, 1945

Immediate cause of death	DURATION
Cerebral Accident	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hyattsville Md Date signed: 4-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

04120 242

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Lanham
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: Lanham
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cross St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Henrietta Theresa Emmerich

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Wm. Emmerich
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct. 11-1863

8. AGE: Years	Months	Days	If less than one day
81	5	24	..... hrs. ..... min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business
FATHER — 12. Name: George C. Hemme
FATHER — 13. Birthplace: Germany
MOTHER — 14. Maiden name: Not Known
MOTHER — 15. Birthplace: Not Known
16. Informant: William E. Emmerich
Address: 1809 Chelsea Road.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 7. 1945 (month) (day) (year)
Cemetery or crematory: Loudon Park.
Location: Baltimore Md.
18. Funeral director: G. Howard Strong
Address: 3707 W. North Ave
19. 4/16 1945 A. W. Hedrick M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

8.00

20. DATE OF DEATH: Apr. 4. 1945 at A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 27 1945 to Apr 4 1945 and that I last saw h[illegible] alive on Apr 2 1945

Immediate cause of death	DURATION
Coronary Occlusion	8 days
Due to: Arteriosclerosis	27 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John J. Maloney M.D. (M. D. or other)
Address: Cheverly Md Date signed 4-4-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-6

CERTIFICATE OF DEATH

04121

Reg. Diat. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 weeks

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 6 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Pr. Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4304 Oglethorpe St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME John Frederick Fey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 3, 1924

8. AGE: Years	Months	Days	If less than one day
20	10	20	hrs. min.

9. Birthplace: New Jersey (Town, county, and state)

10. Usual occupation: draftsman

11. Industry or business: with sub-sanitary Comm.

FATHER — 12. Name: George John Fey

FATHER — 13. Birthplace: Wash D C

MOTHER — 14. Maiden name: Leah Frey Banks

MOTHER — 15. Birthplace: St Louis, Mo

16. Informant: Hospital Records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 1, 1945 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md

18. Funeral director: F. Gasch's sons

Address: Hyattsville Md.

19. May 1 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 28 1945 at 9:57 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28 1944 to Apr 28 1945

and that I last saw h.. alive on Apr 28 1945

Immediate cause of death: Osteosarcoma of Rt Femur with General Metastases — DURATION: 1½ yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Osteosarcoma of Femur

Date of op: June 1944

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Leo Malin M.D. M. D. or other

Address: Riverdale Md Date signed: 4-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04122

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos., 28 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 4 mos., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 714 Rhode Island Ave. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: FIELDS, TROY

3.(b) Social Security Number: 568-01-7853

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married (separated)

6.(b) Name of husband or wife: Della Fields

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): March 7, 1912

8. AGE:

Years	Months	Days	If less than one day
33	1	22	...hrs. ...min.

9. Birthplace: Daytona Beach, Florida
(Town, county, and state)

10. Usual occupation: Porter, in store

11. Industry or business:

FATHER
12. Name: John Fields
13. Birthplace: Raleigh, North Carolina

MOTHER
14. Maiden name: Grace Mongur
15. Birthplace: Sylvania, Georgia

16. Informant: Decedent
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Apr. 30, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D. C.

18. Funeral director: William Lasch

Address: Hyattsville, Md.

19. Apr. 29 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 29 1945 at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DEC. 1st 1944, to APRIL 29 1945

and that I last saw h... alive on APRIL 29 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	6 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ... Injured at work?

23. SIGNATURE: Daniel Leo Pincare M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 4-29-45

STATE OF MARYLAND—CERTIFICATE OF DEATH

(942) 04123

1. PLACE OF DEATH Registration Dist. No. 5 234

County Prince Georges

Village or City Accokeek No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 24 ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

2. FULL NAME Amos Cole Fisher

(a) Residence: No. Accokeek Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Elane Fisher

6. DATE OF BIRTH (month, day, and year) Jan. 4th 1888

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	2	28	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Carpenter

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. U.S. Government

10. Date deceased last worked at this occupation (month and year) April 14th 1945

11. Total time (years) spent in this occupation 40 yrs.

12. BIRTHPLACE (city or town) Delaware - ho other information (State or country)

FATHER

13. NAME James P. Fisher

14. BIRTHPLACE (city or town) Milford Delaware (State or country)

MOTHER

15. MAIDEN NAME Maranda Joseph

16. BIRTHPLACE (city or town) Kent Co. Delaware (State or country)

17. INFORMANT Laura E. Fisher (Address) Accokeek Delaware

18. BURIAL, CREMATION, OR REMOVAL Place Huntley Md. Date Apr 26, 1945

19. UNDERTAKER Hamilton & Lyons (Address) Huntley Md

20. FILED April 25, 1945 Wm. L. Nesbitt Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April (Month) 24th (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from April 16th, 1945 to Apr 24, 1945

I last saw him alive on April 23, 1945; death is said to have occurred on the date stated above, at 8 a. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary Emphysima — Date of onset 4-13-45

Other Contributory Causes of importance: Arteriosclerosis — Cachexia

Name of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of Injury —, 19—

Where did injury occur? — (Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? —

If so, specify

(Signed) Arthur N. Meloy M. D.

(Address) 4400 Bowen Rd. D.C.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, **e. g.**, heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other **contributory causes** of importance:	
Gallstones	*May 1, 1923*

Example II

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other **contributory causes** of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mos., 11 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 5 mos., 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1607 - 30th St. S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: Earl V. Fisher

3.(b) Social Security Number: 577-20-1121

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married (separated).

6.(b) Name of husband or wife: Marguerite Fisher

8.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): August 14, 1881

8. AGE: Years	Months	Days	If less than one day
63	8	3	...hrs. ...min.

9. Birthplace: Morristown, Ohio (Town, county, and state)

10. Usual occupation: Accountant

11. Industry or business: –

FATHER
12. Name: John V. Fisher
13. Birthplace: Wheeling, West Virginia

MOTHER
14. Maiden name: Martha Lippemcott
15. Birthplace: Wheeling, West Virginia

16. Informant: Decedent
Address

17. (Burial, cremation, or removal. Which?) Removal to Date thereof Apr. 17, 1945 (month) (day) (year)

Cemetery or crematory

Location: Alexandria, Va.

18. Funeral director: F. Gaschi Sons
Address: Hyattsville, Md.

19. (Date rec'd by registrar) Apr 17, 1945 Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 17, 1945, at 1:30 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 6, 1944, to Apr. 17, 1945, and that I last saw h.e.r.m. alive on Apr. 17, 1945.

	DURATION
Immediate cause of death: Pulmonary tuberculosis	7 mo
Due to: Tuberculous enteritis	1 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 7/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

04125

CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH:
County: Prince Georges
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: L. G. Sasscers Farm
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.: L. G. Sasscers farm
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Francis Ford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	widower

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 22 - 1913.

8. AGE: Years: 32 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Inwood, Pr. Geo. Co, Md (Town, county, and state)

10. Usual occupation: Farm laborer

11. Industry or business:

FATHER
12. Name: Richard B. Ford
13. Birthplace: Charles Co, Md

MOTHER
14. Maiden name: Martha A. Forbes
15. Birthplace: Charles Co, Md

16. Informant: Richard B. Ford
Address: Upper Marlboro, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 26/45 (month) (day) (year)
Cemetery or crematory: Mt Calvary Carmel
Location: Upper Marlboro, Md

18. Funeral director: J. B. Johnson
Address:

(Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 19 45 at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death: Hemorrhage and shock — DURATION:
Due to: gun shot wounds of chest
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of: 4-23-45
Where did injury occur: Upper Marlboro P.G. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): In yard of home
Means of injury: Shot with shot gun Injured at work? No

23. SIGNATURE: Deputy medical Examiner
M. D. or other
Address: Forestville Md Date signed: 4-23-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

04126

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Riggs Rd & University P.L.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County P.G.

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No. Riggs Rd & University Pl
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME WILLIAM E FRANKE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife Lena Schubert

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1859

8. AGE: Years	Months	Days	If less than one day
85			hrs. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name William Franke
13. Birthplace Germany

MOTHER
14. Maiden name Lena Heidel
15. Birthplace Germany

16. Informant Mrs Lena E. King

Address 5123 5th St. N.W. Washington D.C.

17. Burial, Cremation, or Removal. Which? Burial Date thereof April 6 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Prospect Hill Cem. Washington D.C.

Location Mead D.C.

18. Funeral director W.W. Chambers

Address Riverdale, Md.

19. April 5 1945 James Lewis
(Date rec'd by registrar) By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945 at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1938 to April 1945 and that I last saw him alive on Dec 18 1944

Immediate cause of death	DURATION
Cardio-renal-vascular disease	7 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J.H. Bulbeck M.D.
M. D. or other

Address 766 Rock Creek Rd. Date signed Apr. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-F)

04127

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince Georges
City or town Hampshire Knolls
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months
Hospital, institution, or street address where death occurred:
6603 Medureh Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Hampshire Knolls
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6603 Medureh Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Cosbie Lee Friedman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife David Friedman
6.(c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) April 26, 1914

8. AGE:

Years	Months	Days	If less than one day
30	11	21	hrs. min.

9. Birthplace Fermin County, Va
(Town, county, and state)
10. Usual occupation Waitress
11. Industry or business

MOTHER FATHER
12. Name Henry Pegmon
13. Birthplace Virginia
14. Maiden name Virgie Jones
15. Birthplace Virginia

16. Informant David Friedman
Address Hampshire Knolls, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 4-18-45 (month) (day) (year)
Cemetery or crematory Belle, Mo.
Location
18. Funeral director W W Chambers Co
Address Riverdale, Md

19. April 18 1945 (Date rec'd by registrar) James Severe By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945, at 9.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
asphyxia	
Due to acute Carbon Monoxide poisoning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 4-17-45
Where did injury occur? Hampshire Knolls P.G. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Fumes from gas stove Injured at work? No

23. SIGNATURE Deputy Medical Examiner
M.D. or other
Address Forestville Md Date signed 4-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

04128

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Geo Co.
City or town Cheverly Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred: Prince Georges General Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 318 Main St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mr Carroll D. Frost

3.(b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Nov 26
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Nov 24 1867

8. AGE: Years 77 Months 4 Days 29 If less than one day ... hrs. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Retired: Grocery business

11. Industry or business

FATHER
12. Name Henry Frost
13. Birthplace Md

MOTHER
14. Maiden name Alpina Farrell
15. Birthplace Md

16. Informant Daughter Miss Ethel Frost
Address 318 Main St. Laurel

17. Burial Date thereof April 28/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Philips
Location Laurel Md

18. Funeral director [illegible] Donaldson
Address Laurel Md

19. 4/25 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25 1945, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/29 1945, to 4/25 1945
and that I last saw h— alive on 4/25 1945

Immediate cause of death Acute Cholecystitis
Carcinoma: Pylorus
Due to —
Due to —
Other conditions —
(Include pregnancy within 3 months of death)

DURATION

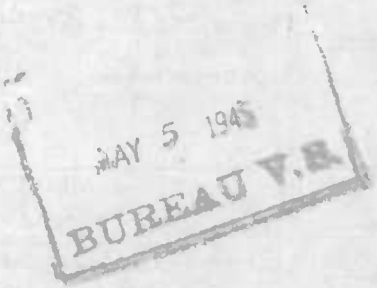
Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE N. B. [illegible] M.D. or other
Address Laurel Date signed 4/25/45

6/2/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

04129

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos 8 days
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 2 mos 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Guyedo Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2302 - 39th Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Moller Gillingham

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Christina Elizabeth Gillingham
6.(c) If alive, give age: 75 years
7. Birth date of deceased (mo., day, yr.): Dec 1, 1865

8. AGE: Years	Months	Days	If less than one day
79	4	20	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Painting
11. Industry or business
FATHER 12. Name: James W Gillingham
13. Birthplace: Va
MOTHER 14. Maiden name: Robie Moller
15. Birthplace: Virginia
16. Informant: Hospital Records
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 24, 1945 (month) (day) (year)
Cemetery or crematory: Glenwood
Location: Washington D.C.
18. Funeral director: F Glecia sons
Address: Hyattsville Md.
19. April 23 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1945 at 10:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942, to April 20 1945
and that I last saw him alive on April 20 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	3 mo.
Due to: General Arteriosclerosis	25 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L W Malin MD M. D. or other
Address: Riverdale, Md. Date signed 4-21-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15K2)

CERTIFICATE OF DEATH

04130

Reg. Dist. No. 245

1. PLACE OF DEATH:

County .....

City or town Mt Rainier, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County .....

City or town Mt Rainier
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4007 - 31st St
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Frederick William Green

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Margaret Ellen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1868

8. AGE: Years	Months	Days	If less than one day
76			..... hrs. ..... min.

9. Birthplace England (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER — 12. Name William Green

FATHER — 13. Birthplace England

MOTHER — 14. Maiden name Alice Morris

MOTHER — 15. Birthplace England

16. Informant Ada D. Green

Address 4007 - 31st St Mt Rainer, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof April 20 1945 (month) (day) (year)

Cemetery or crematory .....

Location Washington DC

18. Funeral director The S. H. Hines Co

Address 2901 - 14 - at N.W. Wash, D.C.

19. April 20 1945 Jas Sevey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 4/20/45

20. DATE OF DEATH April 20 1945 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from April 1, 1945 to April 20 1945, and that I last saw him alive on April 20 1945

Immediate cause of death	DURATION
Congestive Failure	2 yrs.
Due to	
Due to	
Other conditions Cardio-arteriosclerosis, Nephritis-Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frederick Brody M. D. or other

Address 55 W. 42 St NYC Date signed April 20/45

Evidence for change of age is shown on FILM No. G 95 JUN 1 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-7)

CERTIFICATE OF DEATH

04131

Reg. Dist. No. 252

1. PLACE OF DEATH:
County: Prince George
City or town: Mitchellville Annex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Mitchellville Annex
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Charles Belt Grierson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma Horseman Grierson
6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Jan 1, 1865

8. AGE: Years	Months	Days	If less than one day
79 80	3	3	hrs. min.

9. Birthplace: Calvert County Md (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Tobacco raiser
FATHER 12. Name: Walter Fredrick Grierson
FATHER 13. Birthplace: Calvert Co. Md.
MOTHER 14. Maiden name: Rebecca Cochran
MOTHER 15. Birthplace: Calvert Co. Md
16. Informant: Mrs Emma Grierson
Address: Mitchellville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 6 - 45 (month) (day) (year)
Cemetery or crematory: Mt. Hermony
Location: Queen Anne Md.
18. Funeral director: Tolson Brothers
Address: Upper Marlboro Md.
19. Apr 6 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1945 at 7:00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 10 1944 to April 3 1945
and that I last saw alive on April 2 1945

	DURATION
Immediate cause of death: Chronic Myocarditis.	5 years
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert L McGreevy M.D. M. D. or other
Address: 40 Main St Laurel Md. Date signed: 4/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04132

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Prince Georges Co Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D C County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3535 Vista St. N E
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Eunice N. Hansbrough

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Howard H.
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Jan. 19 1884

8. AGE: Years	Months	Days	If less than one day
61			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William Stansbury
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary Thorne
15. Birthplace: Md

16. Informant: H. H. Hansbrough
Address: 3535 Vista St. N E

17. Buried (Burial, cremation, or removal. Which?) Date thereof April 9 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cem
Location:

18. Funeral director: J. Wm Lee Sons
Address: 300-4th St N E

19. 4/6 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 22 1945, to April 6 1945 and that I last saw her alive on April 1st 1945

	DURATION
Immediate cause of death: 6.45 A.M. Acute Congestive Failure	2 weeks
Due to: auricular fibrillation	2 weeks
Due to: Hypertensive cardiac disease	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry J. Hadley M. D. or other
Address: 1252 Eat Pl Date signed April 6 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15-T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04133

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos., 20 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 mos., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1102 - 6th St. S. W
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: Lizzie Harrison

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Willie Harrison
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): January 15, 1889

8. AGE: Years	Months	Days	If less than one day
56	3	1	...hrs. ...min.

9. Birthplace: Carolina, Virginia (Town, county, and state)
10. Usual occupation: Matron - Bureau of Engraving
11. Industry or business: –

FATHER
12. Name: Robert Brown
13. Birthplace: Virginia

MOTHER
14. Maiden name: Moriah Lucas
15. Birthplace: Virginia

16. Informant: Decedent
Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Apr 18, 1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: John T. Pumphrey & Co.
Address: 901 - 3rd St. S.W.

19. Apr 16 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 1945 at 6:55 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 27, 1945 to April 16, 1945 and that I last saw h.. alive on April 16, 1945

Immediate cause of death	DURATION
Tuberculosis Pulmonary	3 Mo-21 da
Due to: Diabetes Mellitus	2 Mo-17 da
Due to: Genito-urinary Tuberculosis	2 Mo-7 da
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale, Md. Date signed: 4/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B1-2)

04134

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County Prince Georges

City or town Marlboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

on farm of B. Buck

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince Georges

City or town Marlboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Henson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Widowed

6.(b) Name of husband or wife Susie Smallwood

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 68 | Months | Days | If less than one day hrs. min.

9. Birthplace A. A. Co Md (Town, county, and state)

10. Usual occupation Farm Hand

11. Industry or business

FATHER 12. Name Charles Henson

13. Birthplace A. A. Co Md

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Nettie Blake

Address Lothian Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 7 1945 (month) (day) (year)

Cemetery or crematory Walkers Chapel

Location Lothian Md

18. Funeral director C. A. Hardesty & Son

Address Galesville Md

19. June 7 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1945 at 7 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardio vascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner James J. Bond M. D. or other

Address Forestville Md Date signed 4-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK (S) Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04135

Reg. Dist. No. 732

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Forestville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Prince Georges County Almshouse

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 4 years 45 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Pr. Georges

City or town: Forestville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Prince Georges County Almshouse.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: William Henry Hinkle

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Widowed

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 30, 1868

8. AGE: Years: 76 | Months: | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Washington Dist. (Town, county, and state)

10. Usual occupation: Book Keeper

11. Industry or business:

FATHER — 12. Name: Henry Hinkle

13. Birthplace: Roxborough, Pa

MOTHER — 14. Maiden name: Elizabeth Bowers

15. Birthplace: Roxborough, Pa.

16. Informant: Almshouse Officials

Address: Forestville, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 4-16-45 (Month) (day) (year)

Cemetery or crematory: Prince Geo. Co. Alms House

Location: Forestville, Md.

18. Funeral director: Pilchie Bros.

Address: Upper Marlboro, Md.

19. April 16 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14, 1945, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-29-1942 to Apr 14 1945, and that I last saw him alive on Apr 2 1945.

Immediate cause of death	DURATION
Chr. Myocarditis & Arteriosclerosis	1
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John D. Maloney, M.D. M. D. or other

Address: Upper Marlboro, Md. Date signed: 4-25-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49-2)

CERTIFICATE OF DEATH

04136

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cottage City.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 1/2 years
Hospital, institution, or street address where death occurred:
3706 - 40th Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Cottage City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3706 - 40th Place
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: CORA LOUISE HOLLOWELL

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Thomas C. Hallowell
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): march 21 1880

8. AGE: Years	Months	Days	If less than one day
65			hrs. min.

9. Birthplace: Mars Hill N.C. (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business:
FATHER 12. Name: Alexander Logan
13. Birthplace: north Carolina
MOTHER 14. Maiden name: margaret Buckner
15. Birthplace: north Carolina
16. Informant: Mr Thomas C. Hallowell
Address: 3706 - 40 St Cottage City Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 25 45 (month) (day) (year)
Cemetery or crematory: Ft Lincoln Cemetery
Location: Prince Georges Co. Md
18. Funeral director: J. William Lees Son Co
Address: 300 - 4 St N.E. Wash D.C.
19. 4/23 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-23 1945 at 2 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-1 1944 to 4-23 1945 and that I last saw h-er alive on 4-23 1945

Immediate cause of death	DURATION
Carcinoma of Ovaries	
Malnutrition	
Due to: Primary Cancer of left ovary	
Duration: 18 months approx	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. J. Hageagund M.D. or other
Address: 317-38 St N.E. Wash DC Date signed: 4-23-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04137

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 4 mos., 5 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 yrs., 4 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Astoria Hotel - 809- 14th St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: EVELYN KING

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: ? King

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 18, 1913

8. AGE: Years	Months	Days	If less than one day
32	-	1	..... hrs. ..... min.

9. Birthplace: York Co., Virginia
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER
12. Name: John T. Hansford
13. Birthplace: York Co., Virginia

MOTHER
14. Maiden name: Lucille Jayne
15. Birthplace: York Co., Virginia

16. Informant: Decedent

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 27, 1945 (month) (day) (year)

Cemetery or crematory: Columbia Gardens

Location: Arlington Co., Va.

18. Funeral director: W. W. Chambers

Address: Riverdale, Md.

19. Apr. 19, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 19, 1945, at 4.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 14, 1942 to Apr. 19, 1945 and that I last saw her alive on Apr. 19, 1945.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	28 mo.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 4/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18 (d)

04138

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George County
City or town: Hyattsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Mother Jones Rest Home
Stay in hospital or inst. (yrs., or mos., or days): 5 years
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Rigge Rd. extended
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Paul K Lee

3. (b) Social Security Number: 205-05-7764

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife: Edith M. Lewis
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 27, 1866

8. AGE:

Years	Months	Days	If less than one day
79			hrs. min.

9. Birthplace: Henrico, Richmond, Va
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: George W. Lee
13. Birthplace: Richmond Va.

MOTHER
14. Maiden name: Jennie Kimbrough
15. Birthplace: Richmond, Va.

16. Informant: Mrs. Mildred L. Henderson
Address: 18-Boyd Ave. Takoma Park.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-28-45 (month) (day) (year)
Cemetery or crematory: Glenwood Cemetery
Location: Lincoln Rd Wash. D. C.

18. Funeral director: William J. Talley
Address: 3200 R.I. Ave. Mt. Rainier, Md.

19. Apr 28 1945 (Date rec'd by registrar) James Levey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1945, at 11.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-18 1945 to 4-25 1945
and that I last saw h him alive on 4-24-45 1945

	DURATION
Immediate cause of death: Myocardial failure	6 days
Due to: Senility	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John R. Clum M.D.
M. D. or other
Address: Hyattsville Md. Date signed 4-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for addition of date of death is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

04139

Reg. Dist. No. 2-72

FILM No. G 95 JUN 5 1945

1. PLACE OF DEATH:
County Prince Georges
City or town Camp Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred: 4851 - Branch Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Camp Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4851 - Branch Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Alverta Marie Malcom

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1945

8. AGE: Years | Months: 1 | Days: 16 | If less than one day: hrs. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Homer Malcom
13. Birthplace Maryland

MOTHER
14. Maiden name Alverta Standyford
15. Birthplace Maryland

16. Informant Homer Malcom
Address Camp Springs Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 4-28-45 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Suitland Md

18. Funeral director H. B. Chambers
Address 317-11 St. S.E. Washington D.C.

19. April 25 1945 Carrie F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1945, at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Asphyxia	
Due to Something in her Clothing	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 4-24-45
Where did injury occur Camp Springs Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Type of injury Smothered in bed by
Injured while

23. SIGNATURE Deputy Medical Examiner
M. D. or other
Address Forestville Md Date signed 4-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04140

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 hours

Hospital, institution, or street address where death occurred:

Eugene Leland Memorial Hospital

How long in hospital or institution? 24 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Mt. Ranier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3602 Shephard St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Eleanor May Markward

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 2, 1945

8. AGE:

Years	Months	Days	If less than one day
	1	5	hrs. min.

9. Birthplace: Riverdale, Prince Georges, Md. (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: Walter (none) Markward

13. Birthplace: Brentwood, Maryland

MOTHER

14. Maiden name: Eleanor Virginia Covington

15. Birthplace: Washington, D.C.

16. Informant: Walter M. Markward

Address: 3602 Shephard St., Mt. Ranier Md.

17. (Burial, Cremation, or removal. Which?) Burial Date thereof (month) Apr (day) 9 (year) 1945

Cemetery or crematory: Evergreen

Location: Bladensburg md

18. Funeral director: F. Gaeller Sons

Address: Hyattsville md

19. (Date rec'd by registrar) April 9 1945

James Bowen By RBB Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-7- 1945, at 9:30 p. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar 2 1945 to April 7 1945 and that I last saw h.er alive on April 7 1945

Immediate cause of death	DURATION
Bronchial Pneumonia	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results: Pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. W. Malin M.D. M. D. or other

Address: Riverdale Md Date signed: 4-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

(4141)

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Pr. Geo. County
City or town: Brentwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr. George
City or town: Brentwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3812 Quincy St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alvonita P. Maurer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Louis R. Maurer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 23 1898

8. AGE: Years	Months	Days	If less than one day
47			hrs. min.

9. Birthplace: Denver, Colo.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Dryhread
13. Birthplace: Switzerland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Louis R. Maurer
Address: 3812 Quincy St. Brentwood Md.

17. Burial, cremation, or removal: Buried Date thereof: 4-7-45 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: Wash. D.C.

18. Funeral director: Lowe Chambers Co.
Address: Riverdale, Md.

19. April 5 1945 (Date rec'd by registrar)
James Deweese By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 - 3 1945 at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 - 8 1944, to 4 - 3 1945
and that I last saw h... alive on 4 - 2 1945

Immediate cause of death	DURATION
Hypertensive Cardio Vascular Disease (Malignant Hypertension)	3 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other
Address: [illegible] Md. Date signed: 4-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (1310)

CERTIFICATE OF DEATH

04142

Reg. Dist. No. 242.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Prince Georges
City or town: Lanham (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred: Whitfield Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Lanham (If outside city or town limits, write RURAL and give nearest town)
Street No.: Whitfield Road (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William Thomas Maynard
3. (b) Social Security Number

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Amy E. Maynard
6.(c) If alive, give age: 54 years
7. Birth date of deceased (mo., day, yr.): Aug 10, 1882
8. AGE: Years 62 Months 8 Days 7 If less than one day ... hrs. ... min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: U. S. Govt
FATHER 12. Name: Thomas P. Maynard
13. Birthplace: Maryland
MOTHER 14. Maiden name: Amy E. Jones
15. Birthplace: Maryland
16. Informant: Amy Maynard
Address: Lanham, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 19 45 (month) (day) (year)
Cemetery or crematory: Mt Olive Cemetery
Location: Washington D.C.
18. Funeral director: Thomas Frazier Co.
Address: 389 - R.I. Ave. N.W.
19. April 17 1945 (Date rec'd by registrar) Mrs Jack Bennett D.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 1945, at 6 45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...
Immediate cause of death: acute congestive heart failure
Due to: Cardiovascular renal disease
Due to:
Other conditions
(Include pregnancy within 3 months of death)
DURATION
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?
Deputy Medical Examiner
23. SIGNATURE: James I. Boyd M.D. or other
Address: Forestville Md Date signed 4-17-45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04143

Reg. Dist. No. 243.

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 11 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 2 mos., 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1225 - 28th St. N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: –

3. (a) FULL NAME: MC. KNIGHT, EVELYN

3. (b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Jessie McKnight (dec.)

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 15, 1911

8. AGE: Years	Months	Days	If less than one day
33	11	15	hrs. min.

9. Birthplace: Bishotsville, South Carolina (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: Jake Boyd

13. Birthplace: Bishotville, South Carolina

MOTHER

14. Maiden name: Emma Prescott

15. Birthplace: Bishotville, South Carolina

16. Informant: Decedent

Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Apr. 30, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: Thomas Frazier W.T.

Address: 38-9 Rhode Island Ave. N.W.

19. Apr. 30 1945 Rowland S. Philips (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 30, 1945 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/19 1945, to 4/30 1945 and that I last saw h... alive on 4/30 1945

Immediate cause of death	DURATION
Tuberculosis pulmonary	3 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pinucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 4/30/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04144

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 mos., 28 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 10 mos., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2301 N. St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I. ✓

3. (a) FULL NAME: WILLIAM. MINOR

3. (b) Social Security Number: 578-20-8735

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Rosetta Minor

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): April 7, 1891

8. AGE: Years	Months	Days	If less than one day
54	-	12	hrs. min.

9. Birthplace: Caroline, Virginia
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business:

FATHER
12. Name: Nathan Minor
13. Birthplace: Virginia

MOTHER
14. Maiden name: Ann Spencer
15. Birthplace: Virginia

16. Informant: Decedent
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Apr. 20, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: W. E. Jarvis

Address: 1432 you St. N.W.

19. Apr. 19, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19th 1945 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 1944 to April 19th 1945 and that I last saw him alive on April 19th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	11 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 4/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BFa)

04145

CERTIFICATE OF DEATH

Reg. Diat. No. 234

1. PLACE OF DEATH:
County Prince Georges
City or town Accokeek
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Accokeek
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Margaret Elizabeth Snyder Morgan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife William B Morgan
6.(c) If alive, give age 75 years
7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 82 | Months | Days | If less than one day hrs. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
FATHER 12. Name Unknown
FATHER 13. Birthplace Unknown
MOTHER 14. Maiden name Unknown
MOTHER 15. Birthplace Virginia
16. Informant William B Morgan
Address Accokeek, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 18-1945 (month) (day) (year)
Cemetery or crematory Congressional
Location Washington D.C.
16. Funeral director Thomas F Murray
Address 2017 - Nichols Ave. S.E.
19. April 15 1945 (Date rec'd by registrar) Howard I Bell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1945 at 9:15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Uremia	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Deputy medical Examiner
23. SIGNATURE Richard J Bard M.D. or other
Address Forestville Md Date signed 4-15-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(4146

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's

City or town (rural) Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 27 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 1 mo., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4547 Lane Place N. E.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME JEANNETTE MORROW

3.(b) Social Security Number 577-32-0556

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Bennie Morrow

6.(c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) September 12, 1914

8. AGE: Years	Months	Days	If less than one day
30	6	4	hrs. min.

9. Birthplace Charlotte, North Carolina (Town, county, and state)

10. Usual occupation Waitress

11. Industry or business

FATHER 12. Name John Jones

13. Birthplace South Carolina

MOTHER 14. Maiden name Alice Mobley

15. Birthplace South Carolina

16. Informant Decedent

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof April 16 1945 (month) (day) (year)

Cemetery or crematory Washington

Location D. C.

18. Funeral director Arthur L. Rollins

Address 4339 Hunt Pl. N.E.

19. Apr 16, 19 45 Rowland S. Philips (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 16 19 45, at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20, 19 45, to Apr. 16 19 45

and that I last saw h-er alive on Apr. 15 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2½ mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D. M. D. or other

Address Glenn Dale, Md. Date signed 4/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2nd)

CERTIFICATE OF DEATH

64147

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: University Park Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs

Hospital, Institution, or street address where death occurred: 4400 Tuckerman St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Pr. Georges

City or town: University Park Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4400 Tuckerman St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ida Isabelle Maul

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fe	W	widowed

6.(b) Name of husband or wife: Martin Peter Maul

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 21, 1863

8. AGE: Years: 82 Months: 3 Days: 1 If less than one day: hrs. min.

9. Birthplace: York Co Penn (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Peter Rebman

13. Birthplace: York Co, Penn

MOTHER — 14. Maiden name: Susan Kroll

15. Birthplace: York Co. Penn

16. Informant: Son Elmer Maul

Address: 4400 Tuckerman St

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 4-23-45 (month) (day) (year)

Cemetery or crematory:

Location: York Pa

18. Funeral director: W. W. Chamber

Address: Riverdale Md

19. April 23 1945 (Date rec'd by registrar) Jas Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 1945 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1941, to April 22 1945 and that I last saw her alive on April 22 1945

Immediate cause of death	DURATION
Myocardial Failure	5 days
Due to: Arteriosclerotic (Heart) H.T. Dis	10 yrs
Due to: General Arteriosclerosis	20 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L W Malin M D

M. D. or other

Address: Riverdale, Md Date signed: 4-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of year of birth of deceased is shown on FILM No. G 95 JUN 1 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04148

CERTIFICATE OF DEATH

Reg. Dist. No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Rural - Laurel (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred: Laurel Sanitarium
How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Rural Laurel Md (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Robert Lee Nichols

3. (b) Social Security Number

4. Sex: M.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Mary E. Hines
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): January 20, 1862 1863
8. AGE: Years 82 Months 2 Days 27 If less than one day ... hrs. ... min.
9. Birthplace: Rural, Laurel - Prince Georges Md (Town, county, and state)
10. Usual occupation: Carpenter - Small farmer
11. Industry or business
FATHER 12. Name: Robert Lee Nichols
13. Birthplace: Md
MOTHER 14. Maiden name: Elizabeth Anne Ridgely
15. Birthplace: Md
16. Informant: R. L. Nichols, Jr. (Son)
Address: Savage, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 19, 1945 (month) (day) (year)
Cemetery or crematory: St. Marys
Location: Laurel, Md.
18. Funeral director: [illegible]
Address: Laurel, Md.
19. Apr. 18 1945 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 1945, at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 1945, to April 16 1945 and that I last saw him alive on April 16 1945

	DURATION
Immediate cause of death: Bronchial Pneumonia	2½ days
Due to	
Due to	
Other conditions: Osteomyelitis, rt hand	4 mos
Senile dementia (Include pregnancy within 3 months of death)	4 mos

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [illegible] McMeen MD (M. D. or other)
Address: Laurel Md Date signed 4/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-C)

CERTIFICATE OF DEATH

04149

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 hours 55 min.

Hospital, institution, or street address where death occurred:

Eugene Leland Memorial Hosp.

How long in hospital or institution? 21 hours 55 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Washington, D.C. County:

City or town: Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3047 30th St. S.E.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME

Unnamed Baby Boy PAINE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 4-17-45

8. AGE:

Years	Months	Days	If less than one day
—	—	—	22 hrs. 55 min.

9. Birthplace: Riverdale, Prince Georges, Maryland (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: Walter Paine

13. Birthplace: Cleveland, Ohio

MOTHER

14. Maiden name: Irene Berryhill

15. Birthplace: Wagon City, Illinois

16. Informant: Mother

Address: 3047 30th St. S.E. Wash. D.C.

17. Burial (Burial, cremation, or removal—which?) Date thereof 4-19-45 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Bladensburg, Md.

18. Funeral director: F. Gaschi Son

Address: Hyattsville, Md.

19. April 19 1945 James Davy (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-18- 1945, at 5:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-17- 1945, to 4-18- 1945 and that I last saw h.x.ng. alive on 4-17- 1945

Immediate cause of death	DURATION
Hemorrhagic Disease of New born with fresh hemorrhage in abdomen	1 Day
Due to: Shock	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Clarence L. Pendry M. D. or other

Address: Leland Memorial Hosp. Date signed: 4-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16)

CERTIFICATE OF DEATH

04150

Reg. Diat. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Unnamed Baby Palmer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 3-21-40

8. AGE: Years | Months | Days: 19 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Riverdale, Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: Earl Palmer

13. Birthplace: unknown

MOTHER

14. Maiden name: Lucille Palmer

15. Birthplace: unknown

16. Informant: Hospital Records

Address

17. (Burial, cremation, or removal. Which?) Cremation Date thereof 4-11-45 (month) (day) (year)

Cemetery or crematory: F. Lincoln Cemetery

Location: Washington D.C.

18. Funeral director: Lord Chamber Co

Address: Riverdale Md.

19. April 11 1945 (Date rec'd by registrar) James Seay Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 9 19 45, at 6 40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 21 19 45 to April 9 19 45

and that I last saw h. s.m. alive on April 9 19 45

Immediate cause of death	DURATION
Congenital atelectasis	19 days
Due to	
Due to	
Other conditions /	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: atelectasis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: L.O. Malin M.D. (M. D. or other)

Address: Riverdale, Md Date signed 4-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

04151

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Calvert Housing Project
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pro Geo Co
City or town: Calvert Housing Project
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6658 - 7th Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mildred Poole

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Joseph Poole
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Oct 2, 1895

8. AGE: Years	Months	Days	If less than one day
49			____ hrs. ____ min.

9. Birthplace: Penna (Town, county, and state)
10. Usual occupation: signal corps
11. Industry or business: Arlington Va

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Mrs Lile Fitzhugh
Address: Calvert Housing Project 2nd
17. Disposition: transportation (Burial, cremation, or removal. Which?) Date thereof: April 14, 1945 (month) (day) (year)
Cemetery or crematory: Farmville
Location: Va
18. Funeral director: E Gasche sons
Address: Hyattsville Md
19. April 14 1945 (Date rec'd by registrar) James Deese By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14 1945, at 8:30 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 5 1945, to April 14, 1945
and that I last saw her alive on April 5, 1945

	DURATION
Immediate cause of death: Carcinomatosis	
Cardiovascular Renal disease	1 month
Due to: Carcinoma of uterus	9 months
Due to: Carcinoma of right breast	10 months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Isidor H. Levine, M. D.
Address: Mt. Rainier Md Date signed 4/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (745)

04152

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 days
Hospital, Institution, or street address where death occurred: 23 day
How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Georges
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5802 Arbor St, Hyattsville, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Reel, Mrs Melvina

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married.

6.(b) Name of husband or wife: Mr. Fulton Reel.
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 25 1900

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
44	~~5~~ 7	2.		

9. Birthplace: Austria Hungary. (Town, county, and state)
10. Usual occupation: H. W.
11. Industry or business:
12. FATHER — Name: Frank Gonda
13. FATHER — Birthplace: austria
14. MOTHER — Maiden name: Jessica Szumanay
15. MOTHER — Birthplace: Hungary.
16. Informant: Mr. Fulton Reel
Address: 5802 arbor St, Hyattsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 30. 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Maryland
18. Funeral director: F. Gascle Sons
Address: Hyattsville Md.
19. 4/29 19 45 Amanda Downes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-27-45 19 ____ at 1:58 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-5 19 45 to 4-27 19 45 and that I last saw h 21 alive on 4-27-45 19 ____

Immediate cause of death	DURATION
Chronic Lymphatic Leukemia	1 month
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Louis H. Jinal M.D. M. D. or other
Address: Cottage City, Md. Date signed: 4-27-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

04153

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Pr. George
City or town: Bettsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Pr. Geo
City or town: Bettsville md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Chilcoate Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frank E. Reynolds

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife: Effie Reynolds
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug-3-1874

8. AGE: Years: 70 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: newyork (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER
12. Name: Reynolds
13. Birthplace: Newyork

MOTHER
14. Maiden name: unknown
15. Birthplace: Newyork

16. Informant: Effie Reynolds
Address: Bettsville md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-27-45 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: Wash. D.C.

18. Funeral director: W.W. Chambers Co
Address: Riverdale md.

19. April 23rd 1945 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 23 1945, at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 5- 1945, to Apr 23 1945, and that I last saw h[illegible] alive on Apr 23 1945.

	DURATION
Immediate cause of death: Myocardial Failure	3 Months
Due to: Coronary Thrombosis	14 Months
Due to:	
Other conditions: Chr. Nephritis	6 Months

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J.M. Wagner M.D. M. D. or other
Address: Laurel Md. Date signed: 4/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04154

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48 min
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 48 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr. George
City or town: Landover Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Baby Ridgeway.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: hrs. 48 min.

9. Birthplace: Prince Geo. Co. Cheverly Md (Town, county, and state)
10. Usual occupation: Newborn.
11. Industry or business

FATHER
12. Name: Roy Ridgeway
13. Birthplace: Va

MOTHER
14. Maiden name: Elizabeth Hetzpeter
15. Birthplace: Va

16. Informant: Mother Elizabeth Ridgeway
Address: Landover. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year): 4/9/45
Cemetery or crematory: Ivy Hill
Location: Laurel Md - Prince Geo Co
18. Funeral director: Ridgley - Selby
Address: Laurel Md
19. 4/9/45 Amanda Downey Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7th at 1945, at 10.30 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9.42 a.m. April 7th 1945 to 10.30 a.m. April 7th 1945
and that I last saw h... alive on April 7th 1945

Immediate cause of death	DURATION
Baby did not breathe	
Due to: Heredo-lues	
Due to: Paternal and maternal condition	
Other conditions: Ichthyosis - Dorsal Spina Bifida - Loqueme foot (right).	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Charles C. Hageage M.D.
M.D. or other
Address: Mt. Rainier, Md. Date signed: Apr. 7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04155

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred: Eugene Leland Memorial Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: E. Riverdale Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4705 Gilford Rd

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Theodore Alexander Sellman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mattie Laura Sellman

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): October 24 1858

8. AGE:

Years	Months	Days	If less than one day
86	6	5	...hrs. ...min.

9. Birthplace: Montgomery, Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: George William Sellman

FATHER — 13. Birthplace: Montgomery Co. Md.

MOTHER — 14. Maiden name: Margaret Hastings

MOTHER — 15. Birthplace: Montgomery Co., Md.

16. Informant: Josephine Beard

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: may 1 1945 (month) (day) (year)

Cemetery or crematory: St Johns

Location: Beltsville Md

18. Funeral director: F. Sasche sons

Address: Hyattsville Md

19. April 30 1945 James Berry

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-29- 1945 at 3 15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from apr 25 1945 to apr 29 1945

and that I last saw h... alive on apr 29 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	1 week
Due to: Hypertension	20 y.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: ...Injured at work?

23. SIGNATURE: L. W. Madden M.D. (M. D. or other)

Address: Riverdale Md. Date signed: 4-29-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04156 T

Reg. Dist. No. 2-32

1. PLACE OF DEATH:

County Prince Georges

City or town Forestville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

Alms House Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Forestville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Alms House Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Henry Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife Ida Smith

6.(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 67 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farm

FATHER 12. Name Anthony Smith

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Martha Smith

MOTHER 15. Birthplace Virginia

16. Informant Ida Smith

Address Forestville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3 40 (month) (day) (year)

Cemetery or crematory St Lukes

Location Meadows Md

18. Funeral director J. B. Johnson

Address Annapolis Md

19. May 3rd 1940 (Date rec'd by registrar) R. Earl Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive on ... 19...

	DURATION
Immediate cause of death Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Deputy Medical Examiner J. A. Bard M. D. or other

Address Forestville Md Date signed 4-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04157

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 9 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 year, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4437 A. Street S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3. (a) FULL NAME: William S. Smith

3. (b) Social Security Number: 577-26-8104

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –

8.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 11, 1924

8. AGE: Years	Months	Days	If less than one day
21	–	26	____ hrs. ____ min.

8. Birthplace: Bethel, North Carolina (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business: –

FATHER
12. Name: James Smith
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Hattie Singletary
15. Birthplace: North Carolina

16. Informant: Decedent
Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Apr. 9 1945 (month) (day) (year)
Cemetery or crematory
Location: Washington, D.C.

18. Funeral director: Henry J. Washington Sons
Address: 467 - 8th St. N.W.

19. Apr. 7 1945 (Date rec'd by registrar) Rowland S. Phillips Deputy registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 1945 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 29 1944 to April 7 1945; and that I last saw h.l.m. alive on April 7 1945

	DURATION
Immediate cause of death: Tuberculous Lungs	3 mo.
Due to: Tuberculous Pharynx	1 mo.
Due to: Tuberculosis of Intestines	1 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pincare MD (M. D. or other)
Address: Glenn Dale, Md. Date signed: 4.7.45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

04158

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: Hyattsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6413 Queens Chapel Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William F. SPIRE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katherine E. Spire

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept., 7th., 1885

8. AGE: Years: 59 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: N.Y. (Town, county, and state)

10. Usual occupation: Pharmacist

11. Industry or business

FATHER — 12. Name: George H. Spire

FATHER — 13. Birthplace: N.Y.

MOTHER — 14. Maiden name: Emma Denman

MOTHER — 15. Birthplace: N.Y.

16. Informant: Dr. Richard L. Spire

Address: 4300 Blagden Ave., N.W.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4/16/45 (month) (day) (year)

Cemetery or crematory

Location: Washington D. C.

18. Funeral director: The L. H. Hines Co.

Address: 2901-14th., St., N.W.

19. April 15 19 45 (Date rec'd by registrar) Jas Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 19 45, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 19 45, to April 15 19 45, and that I last saw him alive on April 14 19 45.

Immediate cause of death	DURATION
Generalized Carcinomatosis	
Due to: Carcinoma of Sigmoid Colon	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. A. T., M.D. M. D. or other

Address: Hyattsville Md. Date signed 4-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64-2)

04159

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:
County Prince Georges
City or town Adelphia
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 7850 Livingston Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland, County Prince Georges
City or town Adelphia
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7850 Livingston Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Martha Bock Starkey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1, 1906

8. AGE: Years	Months	Days	If less than one day
39	3	0	hrs. min.

9. Birthplace Yonkers N. Y. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home

MOTHER FATHER
12. Name Fred Bock
13. Birthplace Germany
MOTHER
14. Maiden name Elsie
15. Birthplace Germany

16. Informant Arthur White Eagle
Address 7850 Livingston Road, Adelphia

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 4, 1945 (month) (day) (year)
Cemetery or crematory St Johns
Location Broad Creek Md
18. Funeral director Sloms Murray
Address 2007 Nicholas ave S.E. Washington D.C.

19. April 1 1945 Horace J Beall
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1945, at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19
and that I last saw h alive on 19

Immediate cause of death — DURATION
1. Hemorrhage
Shock
Due to Gun shot wound
2. Chest and abdomen
Due to
Other conditions Bullet passed through descending aorta at level of 11th thoracic vertebra, almost severing aorta.
(Include pregnancy within 3 months of death)
Major findings of operation Date of op.
Autopsy results as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of 4-1-45
Where did injury occur? Beltsville (City or town) Prince Georges (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Gun-shot, Injured at work? No

23. SIGNATURE James A. Long M. D. or other
Deputy medical Examiner
Address Forestville Md Date signed 4-1-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-O)

CERTIFICATE OF DEATH

04160

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Geo.
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Westley Stevenson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Mary E. Stevenson
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Nov. 9 1877

8. AGE	Years	Months	Days	If less than one day
	67	4	29	hrs. min.

9. Birthplace: Upper Marlboro Md.
(Town, county, and state)
10. Usual occupation: Labor
11. Industry or business
FATHER 12. Name: John Stevenson
13. Birthplace: Md.
MOTHER 14. Maiden name: Ellen Steward
15. Birthplace: Md.
16. Informant: Mary E. Stevenson
Address: Upper Marlboro
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 5 1945 (month) (day) (year)
Cemetery or crematory: Union Cemetary
Location: Upper Marlboro Md.
18. Funeral director: J. B. Johnson
Address: Jamestown Md.
19. Apl 4 1945 (Date rec'd by registrar) R. Bud Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 21 1945, at 2 45 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cerebrovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Deputy medical Examiner James J. Boyd M. D. or other
Address: Forestville Md. Date signed 4-2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04161

Reg. Dist. No. 245

1

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5725 - 43 Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Orlando Fairbank Sykes

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen Sykes
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Oct 28, 1883

8. AGE: Years	Months	Days	If less than one day
62			hrs. min.

9. Birthplace: Va (Town, county, and state)
10. Usual occupation: Attorney
11. Industry or business: General accounting office

FATHER
12. Name: Gustavus M Sykes
13. Birthplace: Va

MOTHER
14. Maiden name: Annie Laurie Sykes
15. Birthplace: Va

16. Informant: Mrs Helen Sykes
Address: Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 24. 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor Md

18. Funeral director: F Gaeckis Sons
Address: Hyattsville Md

19. April 24 1945 (Date rec'd by registrar) Jas Devery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22, 1945, at 3.15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943, to Apr 22 1945
and that I last saw h[illegible] alive on Apr 2 1945

Immediate cause of death: Myocarditis — DURATION: 1 yr

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thomas Harp M. D. or Coroner
Address: Hyatts. Md Date signed: 4/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

04162

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince George
City or town: Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Seat Pleasant.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 421- 70th St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: LOUISE BRENDT TAYLOR

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: LESTER E TAYLOR
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Apr. 25, 1881

8. AGE: Years	Months	Days	If less than one day
63	11	17	hrs. min.

9. Birthplace: Germany
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: Brendt
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Lester E Taylor
Address: 421-70th St Seat Pleasant Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 11-1945 (month) (day) (year)
Cemetery or crematory: Addison Chapel Cemetery
Location: Seat Pleasant Md.

18. Funeral director: Geo W Wire Co. Inc.
Address: 2900 M st nw Wash. D. C.

19. April 9 1945 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 8 1945, at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1940 to Apr 8 1945 and that I last saw h... alive on April 7 1945

Immediate cause of death: Coronary Occlusion
of Thrombosis with arteriosclerosis — DURATION: 10 yrs
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William Brannin M. D.
Address: Capitol Heights, Md. Date signed: 4/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04163

Reg. Dist. No. 232

1. PLACE OF DEATH:
County: Prince Georges
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred: Brown Station Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Brown Station Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William A. Vermillion

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Lilly R Vermillion
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 17-1856.

8. AGE:

Years	Months	Days	If less than one day
89	1	6	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
12. Name of father: John Vermillion
13. Birthplace of father: Anne Arundel Co., Md.
14. Maiden name of mother: Sarah Vermillion
15. Birthplace of mother: Anne Arundel Co., Md.
16. Informant: Mrs. Wm. A. Vermillion
Address: Upper Marlboro, Md.
17. Burial, (Burial, cremation, or removal. Which?) Date thereof 4-26-45. (month) (day) (year)
Cemetery or crematory: Epiphany
Location: Forestville, Md.
18. Funeral director: Pierce Brothers
Address: Upper Marlboro, Md.
19. Apr 25 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 1945, at 9:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to April 23 1945
and that I last saw h... alive on April 21 1945

Immediate cause of death: Congestive heart failure — DURATION:
Due to: Cardio vascular renal
Due to: disease
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T. Boyd, M. D. or other
Address: Forestville Md. Date signed: 4-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (475)

04164

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:
County: Prince George's
City or town: Branchville R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred: No
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Branchville R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Francis Weinelt

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Weinelt
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): January 17 1880

8. AGE: Years 65 | Months 3 | Days 5 | If less than one day: ... hrs. ... min.

9. Birthplace: Turnau - Germany
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER
12. Name: John Weinelt
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna
15. Birthplace: Germany

16. Informant: Bertha Weinelt
Address: Waldorf, Md

17. Burial, cremation, or removal. Which? Burial Date thereof 4-26-45 (month) (day) (year)
Cemetery or crematory: St Peters
Location: Waldorf Md

18. Funeral director: Hamett & Byrne
Address: Waldorf Md

19. 4-23 19 45 — M. P. Moore
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 19 45 at 7:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 19 45, to April 22 19 45 and that I last saw h[illegible] alive on April 20 19 45

Immediate cause of death	DURATION
Carcinoma Larynx	3 yrs.
with metastasis to	
Due to liver & lungs	
Due to	
Other conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op. —
Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury — Injured at work?

23. SIGNATURE: James E. Spencer, M. D. or other
Address: Upper Marlboro, Md Date signed 4-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 04165

Reg. Diat. No. 23 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Clayton md (Prince Geo Co)
City or town: Clinton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Clinton Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Clinton Md
(If rural, give LOCATION)
2.(a) If veteran, name war: — no —

3. (a) FULL NAME: Nellie Eleanor Wiseman

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	negro	Married

6.(b) Name of husband or wife: James Wiseman
6.(c) If alive, give age: unknown years
7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
about 62"			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: — at home

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: James Wiseman
Address: Clinton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-3-45 (month) (day) (year)
Cemetery or crematory: St. John the Apostle
Location: Clinton, Md.

18. Funeral director: Ritchie Brothers
Address: Upper Marlboro, Md.

19. May 3rd 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 19 45 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 10 19 45 to April 30 19 45 and that I last saw h— alive on April 28 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 days
Due to: Foreign ob. of Left Side of body	unknown
Due to: Cerebral Arteriosclerosis	
Due to:	
Other conditions: — none —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene E Van Valtz M. D. or other
Address: Washington 1962 Date signed: May 1 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04166

CERTIFICATE OF DEATH

Reg. Dist. No. 2-2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges.
City or town: Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years.
Hospital, Institution, or street address where death occurred:
7000- Central Ave
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7000 Central Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John. Everett Wood.

3.(b) Social Security Number: 577-22-4574

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of husband or wife: Gertrude Emma Wood. 6.(c) If alive, give age: deceased years

7. Birth date of deceased (mo., day, yr.): April 18, 1881

8. AGE: Years: 63 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Prince Fredrick, Calvert County, Md.
(Town, county, and state)

10. Usual occupation: Tool-House Clerk.

11. Industry or business: Army Air Base

FATHER — 12. Name: John. Wood.
13. Birthplace: Maryland.

MOTHER — 14. Maiden name: Alice Bell
15. Birthplace: Maryland.

16. Informant: Mrs. Phillip Wood.
Address: 2501-51st st, Tuxedo, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 6, 1945 (month) (day) (year)
Cemetery or crematory: Addison Chapel
Location: Seat Pleasant Md

18. Funeral director: L Gaschè Sons
Address: Hyattsville Md.

19. Apr 4 1945 (Date rec'd by registrar) Irene A. Conner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1945 at 9:35P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1 1945 to April 3 1945
and that I last saw him alive on April 3 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to: Hypertension with generalized arteriosclerosis	>
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William Brannin M. D.
Address: Capitol Heights, Md. Date signed: 4/5/45